Rhode Island Affordability Standards: A Primary Care Focus

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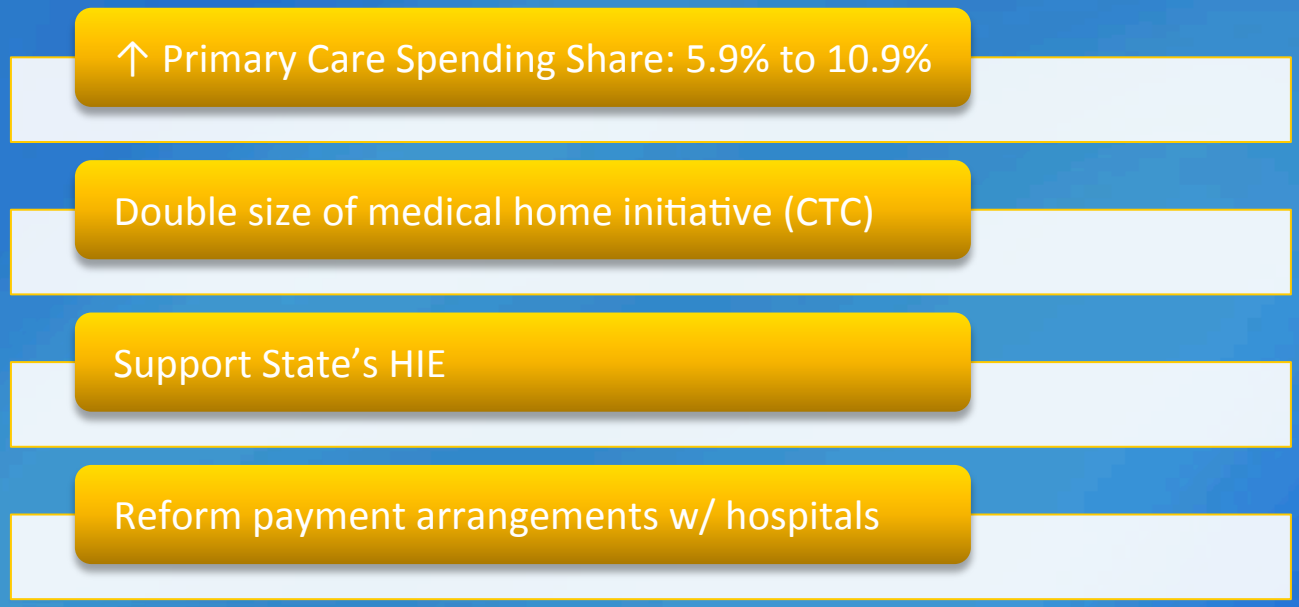
The Policy

- Office of the Health Insurance Commissioner
  - Applies to state-regulated commercial insurers
    - (1/4 of RI insured, 300,000 people)
- Four Standards:



- Total P.C. spend in 2009: $50 million

Primary Care Spend Standard

- Fundamental Aim: Improve system performance and fuel payment/delivery reform

- Increased P.C. Spending Cannot:
  - Lead to higher premiums
  - Increase overall medical spending

- Insurers have discretion on approach

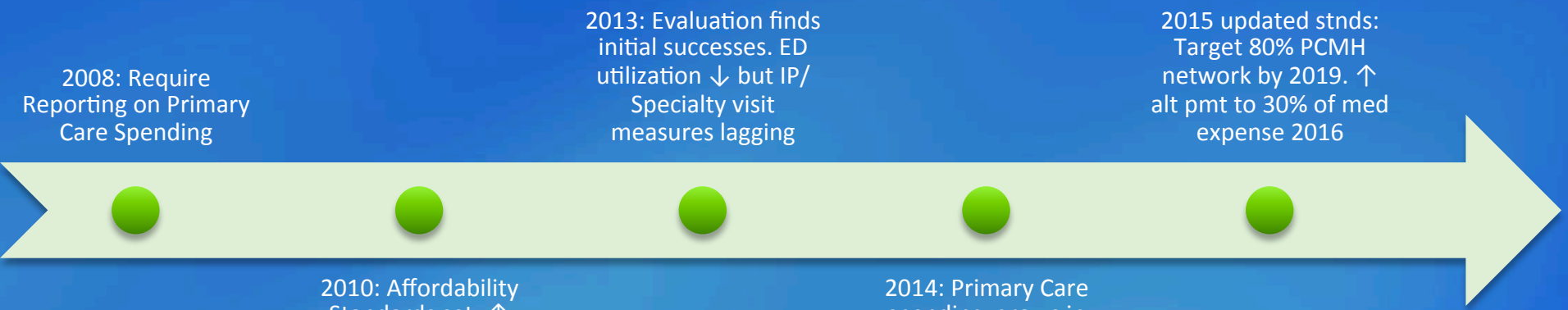
- 2013 Evaluation*
  - Practices used $ to build practice capacity, not ↑ pay
  - Evaluators: "The Primary Care Standard appears to have had a profound impact on primary care practices' ability to transform"

*Source: Assessment of the Rhode Island Affordability Standard, Final Report. *Bailit Health Purchasing*. August 2013

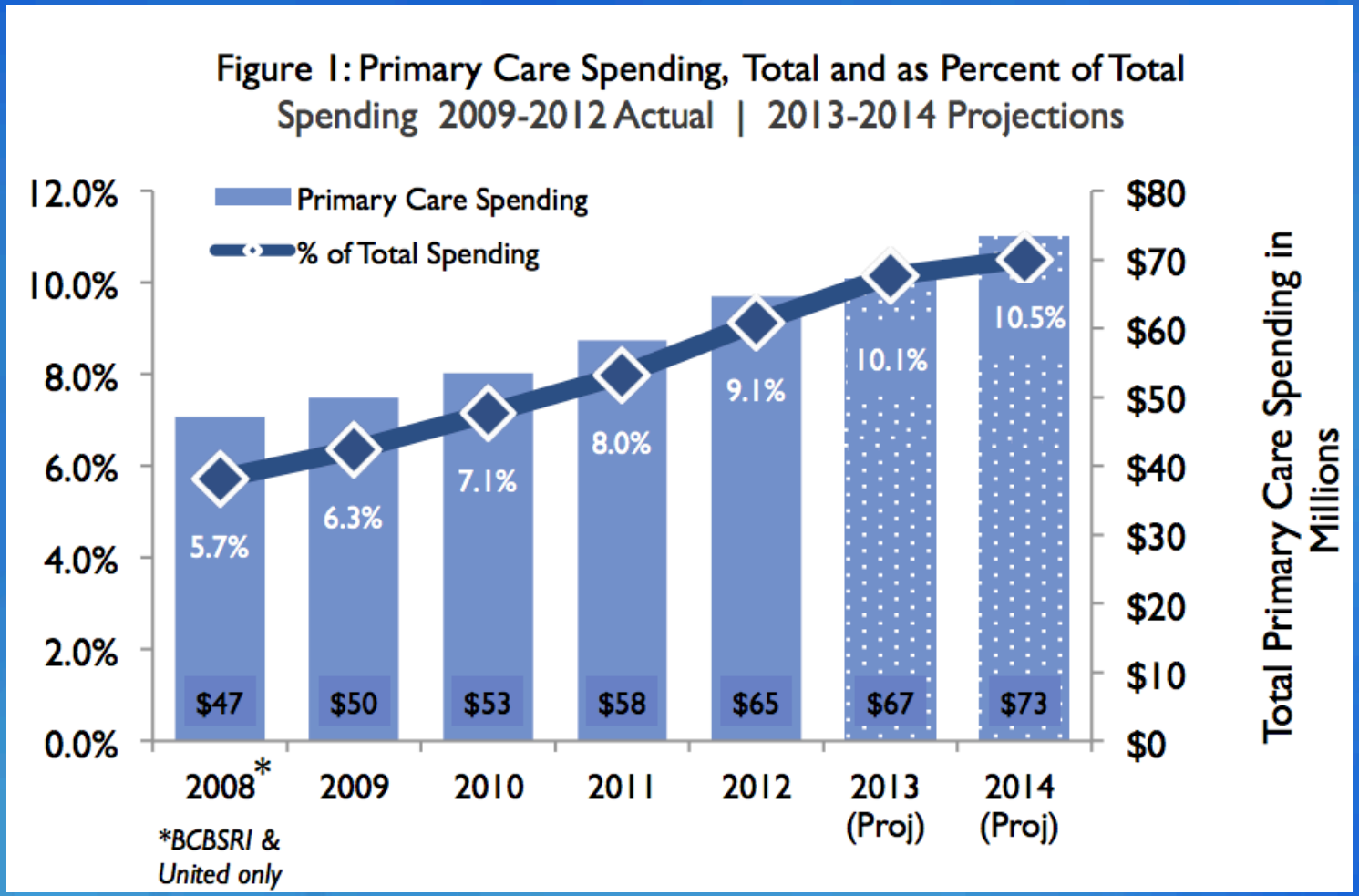
Insurer Approaches

- 3 dominant carriers
- BCBS
  - 50% of ↑ P.C. money goes to PCMH support, PMPM payments for case managers
- United
  - 25% of ↑ P.C. money toward PCMH support
  - 25% Pay for Performance
  - 25% for ↑ to fee schedule (United trailed market on some fees)
  - P.C. loan forgiveness support
- Tufts (Not subject to value-based payment Standard)

Affordability Standards: Timeline



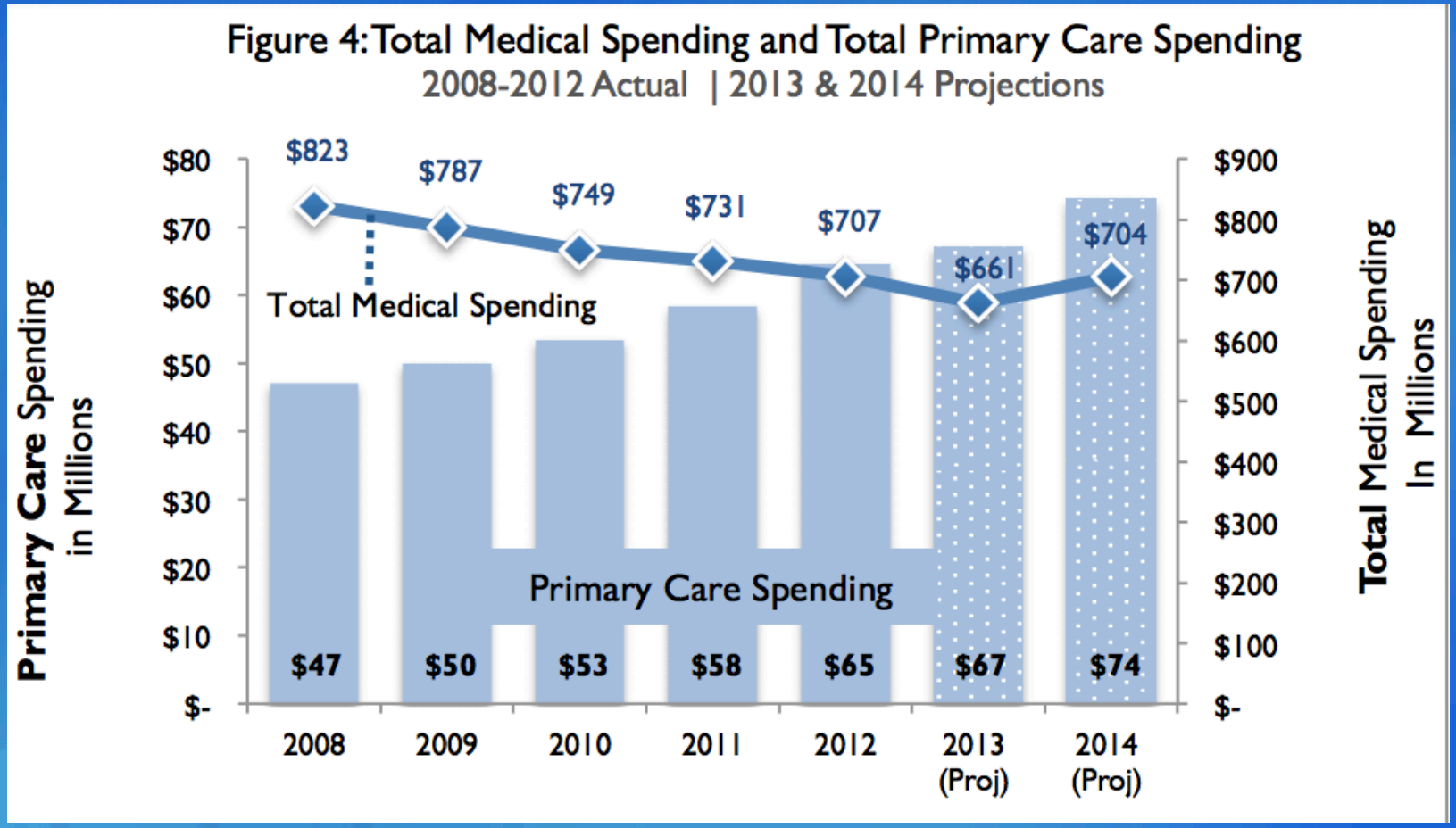
Outcomes: Spending Targets



Source: 2014 OHIC Report: Primary Care Spending in Rhode Island

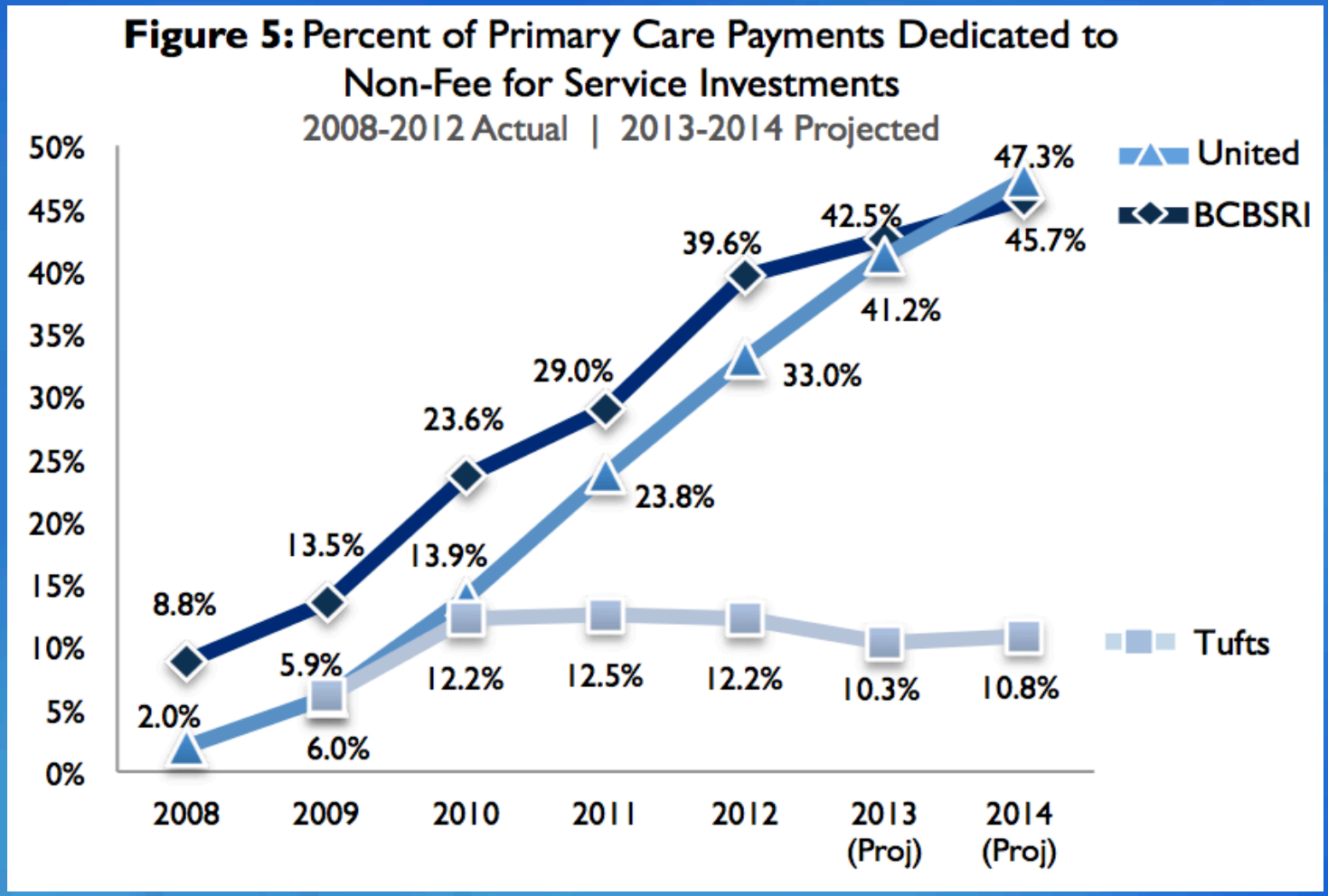
Outcomes: Medical Spending

P.C. Spending ↑



Source: *Ibid.*

Outcomes: Rising Value-Based Payments



Source: *Ibid*.

Outcomes: Care Transformation Collaborative

Multi-payer Early results: ↓ ED, but not significant IP or specialty utilization ↓.
As of 2014, beginning to see all measure improvement

Cohort 1

Group	Changes 2013 - 2014	
	Difference (B-A)	% Difference (B-A)/A
All-cause inpatient admissions per 1000 member months:		
(1) CTC Cohort 1	-0.54	-6.2%
(2) Comparison	0.26	2.5%
Difference (1-2)	-0.80	**-8.7%**
All-cause ED visits per 1000 member months:		
(1) CTC Cohort 1	0.51	1.8%
(2) Comparison	1.40	5.7%
Difference (1-2)	-0.89	**-3.9%**

Cohort 2

Group	Changes 2013 - 2014	
	Difference (B-A)	% Difference (B-A)/A
All-cause inpatient admissions per 1000 member months:		
(1) CTC Cohort 2	-0.23	-2.4%
(2) Comparison	0.26	2.5%
Difference (1-2)	-0.49	**-4.8%**
All-cause ED visits per 1000 member months:		
(1) CTC Cohort 2	0.50	2.3%
(2) Comparison	1.40	5.7%
Difference (1-2)	-0.90	**-3.4%**

Source: CTC

Policy Options

- Assess primary care spending share in CO
  - APCD likely has capability
    - Question of definitions & "indirect" primary care spending (e.g. PMPM, incentive programs, etc.)
  - Oregon will have spending data Dec 31, 2015
    - Contemplating RI approach
- System spending targets
  - Step 1 is knowing where we want to be as a state
  - ? of payer inclusion – MK, MC, commercial, ERISA
- Determine mechanisms of accountability
  - RI Commissioner has significant authority

Resources

- 2014 OHIC Report: Primary Care Spending in Rhode Island http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf
- Affordability Standards August 2013 Evaluation:
  - http://www.oregon.gov/oha/OHPB/2013MeetingMaterials/Affordability%20Standards%20Report,%20Michael%20Bailit.pdf
  - http://www.ohic.ri.gov/documents/HIAC-Affordability-Standards-Evaluation-Findings-May-2013.pdf
- Rhode Island's Novel Experiment to Rebuild Primary Care from the Insurance Side. Health Affairs 2010. http://content.healthaffairs.org/content/29/5/941.full
- Care Transformation Collaborative: https://www.ctc-ri.org/

Thank You

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